Women's Health Council Meeting
January 31, 2007
Sacramento
Meeting Summary

In attendance:
Women's Health Council: Golnaz Agahi, Gilda Arreguin, Yali Bair, Namju Cho, Bev Ching, Crystal Crawford, Karen Dalton, Raquel Donoso, Rae Eby-Carl, Ellen Eidem, Tina Escareno, Sandra Naylor Goodwin, Crystal Hayling, Ruth Holton Hodson, Adele James, Martha Jessup, Shelly Mitchell, Marj Plumb, Catherine Quinn, Diana Ramos, Beatriz Solís, Joan Stevie, Sarah Samuels, Alina Salganicoff, Mili Trevino-Sauceda, Tracy Weitz, Jane Zones
Office of Women's Health (OWH) Staff: Jonelle Chaves, Tinah Concepcion, Christina Florente, Sarah Justinich, Terri Thorfinnson, Zipora Weinbaum
California Department of Health Services (CDHS) Staff:, Heidi Bauer, Jacquie Duerr, Tamar Foster, Lisa Hershey, Leslie Holzman, Don Lyman, Kathleen Mintert, Seleda Williams, Bernie Valdez

Opening Comments
Beatriz Solís, Chair, Women's Health Council
Marj Plumb, Vice Chair, Women's Health Council

- Meeting commenced at 9:30
- Minutes moved by Marj Plumb and unanimously approved
- June 6, 2007: next Council meeting in Sacramento

OWH Update
Zipora Weinbaum, OWH, CDHS

- Each council member received a copy of the 2003-2004 Data Points, along with a summary in the presentation materials.
- The meeting packets contained the Department of Social Services all county letter regarding the implementation of the human trafficking legislation.

Beatriz asked the Data Committee to quickly look at statistics compiled in the Data Points. Some ideas included:

- Alina: Suggested sponsoring a legislative briefing in May regarding the state of the health of women in California. The convergence of Women's Health Month and the report being released in May would offer a good opportunity.
- Council members: Recommended using other data sets to bolster the findings of the California Women's Health Survey. In doing so, it may be possible to find rural and urban separations, if not county separations. Survey Research Group could code for rural and urban populations in future surveys. Sample size is a challenge.
- Martha: Would staff would be available for presentations at future meetings? OWH indicated that they would.
- Tracy: Could consider posting some instruction on internet to act as online training on how to use data points.

- Ellen: Available staff should attend the Los Angeles Office of Women's Health policy summit on May 24, 2007.
- Ruth: Use Data Points to frame a statistic every day during the month of May, point by point.

Governor's Health Care Reform

The Governor's plan is a hard-hitting public ad campaign aimed at making workplaces healthier. Improvements include sidewalks and bike paths to encourage people to lead more active lifestyles. The plan stresses a shared benefit with individuals having access to individual care and the government benefiting from a more active and productive workforce.

Ruth Liu, Health & Human Services Agency

The health care system as it currently stands is dysfunctional and cannot be sustained. Although it is a problem for the uninsured, it is a problem for the insured as well. The main issue is cost, with 10% of hidden tax directed to pay for health care for the uninsured and 7% for underpayment of Medi-Cal services to reimburse care providers. Spending on health care continues to increase and outpace inflation. The keystones of saving money on health care costs are prevention, health wellness efforts, and patient safety. The goal of the reform is to reduce the hidden tax, lower cost, bring people to a healthier California, and support better care. The Governor believes these goals can be achieved through prevention/health wellness, shared responsibility, coverage for all, and affordability.

Prevention and wellness are necessary for people to take better care of themselves. Some things being considered are healthy incentive reward products. All legal resident adults will be eligible for Medi-Cal for those up to 100% of federal poverty level (FPL). People at 100% to 200% FPL will be eligible for subsidized insurance through Managed Risk Medical Insurance Board (MRMIB), probably a little higher than employer coverage would provide. People over 250% FPL must have a $5000 high deductible product with basic preventive screenings available for smaller co-pay amounts. All children, regardless of immigration status, will be eligible for Medi-Cal up to 350% FPL. The average individual premium will be $100 per month per individual, with a healthy population.

Most large employers provide insurance: 65% of employers and most people work for large firms. However, 80% of all employers have less than ten employees and do not have insurance. Most women covered thru insurance have insurance through their spouses, not independently. The most vulnerable population and most likely to not carry insurance are divorced, single or widowed women.

The state will be increasing the Medi-Cal reimbursement rates up to 85% for outpatient and physician visits and 100% of inpatient care. The state recommends each health care plan spend 85% of funding on direct patient care. Medi-Cal liability issues have been considered. Laws that California has in place are good in comparison to other states. The administration is aware that it contributes to health care costs, but in comparison, California is in good standing. Agency still needs to work out the details and is asking for suggestions on how to make the plan a reality.

The Governor's team is talking to stakeholders to get feedback about what items need closer scrutiny, as well as talking to legislative leadership. Two to three page fact sheets will provide additional details. The fact sheets will be put on the Governor's website as they are approved (the fact sheets can be viewed at the following links: http://gov.ca.gov/index.php?/fact-sheet/5334, http://gov.ca.gov/index.php?/fact-sheet/5633). The completion of the legislative language is unknown. It is anticipated that an author will be found or it will be amended into existing vehicles.

The Administration anticipates that pay for performance will improve quality. There is hope that hidden tax will assist in cost containment and dampening the costs of providing care. The cost of health care will increase moderately. The prevention health wellness efforts and diabetes measures will take more time, but will help with underlying drivers of cost.

Counties will be responsible for providing undocumented adult population health care. Right now counties spend about $4 billion for 100% of adults below FPL. Of the $4 billion, counties revert $2 billion to the state to continue to provide services to indigent populations. The counties will provide full scope Medi-Cal for individuals and counties should have enough funding to do so with their populations.

The administration intends to establish a bright line in Medi-Cal. The Administration is aware there are controversial components to the reform package. All individuals below 100% FPL are eligible for Medi-Cal with people over 100% FPL not being eligible, regardless of what program it is.

The Administration asked the Council members for assistance. The Administration knows that the counties have a vast amount of public health issues, with a lot of the funds being held for public health services, not just indigent care. Since California lacks a good statewide criterion, each county uses funds very differently. Working with the county associations, the administration would like to know how to continue to provide public health services and cover the indigent population.

The administration indicated that strong letters of support would be highly appreciated as support from stakeholders would help keep momentum moving forward for the broad proposal. Press announcements along with support letters from the Council would be helpful.

The state will enforce the mandate for individuals to obtain health insurance coverage through certification on state tax forms. There will be a tax penalty for those that file taxes without insurance. If the individual is employed through a system he or she will have to certify that insurance has been provided or a tax penalty will be assessed. Since people are concerned with it; the mandated product is up for debate.

Legislative Health Care Reform
David Panish, Senate President pro Tem Don Perata's Office
SB 48 proposes to cover all Californian's and their dependents, all children up to 300% FPL regardless of their immigration status. The plan would use the MRMIB as the purchasing power. It is a managed competition model so that the purchasing pool would contract with a variety of plans, similar to CalPERS. Cost containment measures would exist as a matter of contract.

The trust fund established for financing would come from a pay or play mechanism. People would be responsible for paying a percentage of their wages. Expand Medi-Cal 1931b program. The enforcement of the legislation will be through a tax code, with the individual mandate for people to show coverage through a health insurance program.

The ability to do something significant and useful to individuals this year has led to the support of the legislation from members. The health care product offered to Californian's may end up being a single payer system; however, this is achievable as a goal this year.

When the Council suggested a need for tracking goals and determining if they are met, Panish agreed. The single payer issue will be talked about for some time to come.

Details are still in the process of being determined. There will be opportunities for public input.

Payment for subsidies is do-able. Health care coverage for all people is the first move towards universal health care. Just as we have a system that pays for disabilities and unemployment, a system should be in place for health care coverage for the unemployed.

Change for people currently in the Medi-Cal program, including working parents up to 300% FPL, is not anticipated. Approximately 40% of the uninsured meet the criteria and will be treated the same as those that are not parents and are within 300% of FPL. The proposed system will be in addition to the current Medi-Cal program. Under a federal waiver and the Deficit Reduction Act (DRA) there is more flexibility. But the question is how do you pay for the federal match? The employee and employer contributions coming into the pot are used for the match to draw in the federal funds. The rest is a question of how it happens administratively. There is a need to have money coming in to offset how to pay for care for low income people. These issues are clearly of importance to women that are underserved.

More detailed information about Senate President pro Tem Don Perata's health care reform can be found on his website: http://dist09.casen.govoffice.com/.

Director's Update
Sandra Shewry, Director, CDHS
Acknowledged the importance of having Ruth Liu and David Panish at the meeting as a testament to the stature of the Council.

Administrative responsibilities of the department related to health care reform
California Department of Public Health (CDPH):

- Administering agency for the obesity plan which would be a compliment to the Governor's plan and will be modeled after the success of the tobacco program. Tobacco funding has increased funds for language access and cessation services.
- Patient safety component will be the nucleus of the public safety element in the reform package.
- Responsible for electronic writing of prescriptions.
- The diabetes initiative will be jointly administered with the Department of Health Care Services (DHCS) to develop pre-diabetic interventions so people with elevated blood sugars can avoid diagnosis of the disease.

Department of Health Care Services (DHCS):

- Will remain the single state agency for Medi-Caid. All medically indigent adults will be eligible for Medicaid. There will be a uniform system providing equal access. Undocumented children under 300% FPL will be eligible for Medicaid, but served through the Healthy Families program. The advocates will probably push back and ask for the "bright line" to be drawn higher. We need to figure out a non-disruptive way to get the children that are eligible over to the Healthy Families program.
- To the extent that Medi-Cal funds are involved, DHCS will be the driver. A federal waiver would be administered thru DHCS, like the diabetes initiative and the Healthy Families programs which offer direct incentives to people

for preventive health interventions. This requires a waiver because a transportation or pharmacy voucher may be given to women for getting their mammograms. If we want to use federal money to provide services that are not categorically entitled to it, that practice will require a federal waiver.

General updates/concerns regarding proposed health care reform plans
Incentives must be relevant to consumers. For example, giving vouchers for gyms that are not within the capability of low income families to use are useless.

In regards to undocumented women and the programs that currently serve them, we need to figure out how to determine immigration status in order to ensure our ability to claim federal funds. The question of what kind of system we are to embrace results in a policy conundrum. Program availability for women depends on what happens. Reproductive services are very necessary, but we need to determine in general what women will and will not have access to services.

Discussions regarding how the different programs rank should take place during the summer. At that point more information about where women are and what programs are needed will be available. Currently, undocumented women are a niche population, but very important. One of the services they will continue to need access to is family planning services; continued access needs to be discussed.

The modified community rating in the governor's plan now is intended to mimic the existing language. Having a reimbursement system that is fair for providers will make California a more attractive place for providers.

Dental and vision are the services that will be the most in flux because most working families have a need for those services once insured. Is the state gearing up for that? The state is fully aware of the demand for dental. Vision checks are also on the horizon.

There is a concern to retain the work that was developed with the Governor's obesity initiative to carry it over to the health care side once the department splits. This may be one of the issues which the Office of Clinical Preventive Medicine in DHCS will need to link back to the colleagues in public health.

Public Health Advisory Committee Update
CDHS is currently soliciting nominations for the Governor's Office. Nine of the fifteen committee members will be appointed by the Governor; the remainder will be legislatively appointed. Cross relationship will exist on both committees. If nominees are on the Women's Health Council, it would be a plus/positive on résumés.

Legislative Health Care Reform (Continued)
Terri Boughton, Assembly Health Committee, Nuñez
Speaker Nuñez proposes a fair share health plan with the guiding principle that insurance is not currently available, affordable, or accessible.

There would be no individual mandate. Employers would be responsible except those under $100,000 or with two or less employees. Exempt for costs that exceed reasonable amount. CalCHIP will offer at least three plans, with uniform benefit designs. All employees who are offered coverage will be required to accept. Excludable conditions will put people in the high risk pool. Health plans will provide services and share costs of patients in high risk pool.

The intended ways to reduce costs are: uncompensated care, prevention disease management for cost containment, pay for performance measures, IT based health records, electronic health records, healthy lifestyles, simplified benefit.

By July 1, 2008 all uninsured should be covered.

Evaluation: Annual assessment of impacts, costs, and quality of care. After five years the state will conduct a comprehensive evaluation to determine if the goals are being met.

Hearings are currently being planned. All were invited to come to Assembly Health Committee room 4202 February 20, to comment on proposals. Follow-up will be held February 27.

Council Discussion on Health Care Reform
Throughout the health care reform discussion many concerns were brought up by Council members. These concerns have been categorized and listed below. No solutions were determined.

Evaluation Component

- Council would like to reserve the right to ask Agency to report back annually with progress made as a result of the reform.
- Recommend that annual monitoring is conducted with a complete evaluation of the impact within five years.
- Concern about when the reform is implemented, whatever system is approved will become the standard operating mechanism and even if the system does not improve health status, the state will not move towards single payer.

- It is not uncommon that program planners may not be able to anticipate all potential adverse problems. Those can be better identified during program implementation. Documenting unintended consequences will be helpful in building a better overall reform.
- Would like to recommend a sunset date; if progress is not made during a specific period of time, something should happen. Monitoring and evaluating should occur as we go through the process, there shoud be adjustments along the way.

Access to Comprehensive Care

- Concern that the reform will result in women just beyond 100% of FPL having diminished access to health care services.
- Intent of the administration to establish a bright line in Medi-Cal, that no one over 100% of FPL will qualify or receive services from Medi-Cal, regardless of the program. This shift will have a disproportional impact on women, especially with regard to access to prenatal care.
- Great concern that lower income women will only be able to afford bare bones high premium plans which may not include prenatal care.
- Concern that the most vulnerable, less commercially savvy women may not be aware of the services available or not available to them thru their plans.
- The most vulnerable women as consumers will not be making the best choices for insurance because they will be limited by cost of premiums, not the best benefit package.
- Unless minimum standards are dictated for benefits offered in packages, there will continue to be a need for the safety net plans like Family PACT.
- How will current Medi-Cal recipients be affected by the changes? Council is concerned that underserved women will be disproportionately affected.
- Employer based insurance that has a threshold based cap and the lack of detail on what benefits are covered (e.g., lack of delivery coverage).
- Greatly concerned with continued existence of Family PACT program and the ability for undocumented women to continue to receive their pregnancy care through the program.
- Issues of undocumented women's access to mental and physical health programs.

Disproportionate Share of Women Impacted

- A disproportionate share of the uninsured are women who are working and have dependent(s).
- Evaluate with a gender lens, what is the impact on women in California. Treating everyone the same does not work.

Fiscal Issues

- Concerned about the public health issues for counties, and whether that will result in a decrease in public health services. Much of the funds at the county level are being used for public health services, not just indigent care. Each county uses funds very differently, and there does not appear to be good statewide criteria available for use.
- The issue of cost containment is the elephant in the room that no one wants to talk about. Hard to get a handle on the rate of growth in medical measures.

Lack of culturally appropriate providers to handle additional patient load

- Is it possible to consider requiring all physicians in California that receive a medical license to accept Medi-Cal?
- Concern expressed about the flood of people coming into the insurance world. Relates to discussion around Family PACT that has special benefits for a lot of uninsured women.
- Cultural and linguistic issues, promotores, community health workers are not evidenced based, but effective in communities of color.

Medi-Cal/Family PACT Update

Stan Rosenstein, Deputy Director, Medical Care Services, CDHS

Medi-Cal continues to do very well budgetarily. The Governor's budget is generous. In the pharmacy arena, California is known as being the highest payer anywhere. The proposed budget decreases the cost. There are far less decreases in the proposed budget than have been suffered in the past. The intent is to protect and expand Medi-Cal eligibility.

The proposed budget covers the human papillomavirus (HPV) vaccine for 19-26 year old women. Funding part of Medi-Cal resources for indigent care services. Medi-Cal is also receiving increases for doctors for reimbursement for care. A strong federal funding source has been confirmed, discretionary out of $5.4 billion is only $250 million.

In an effort to streamline Medi-Cal, they are looking for two counties that will pilot self certification for benefits. Medi-Cal is in the process of implementing the DRA and have not yet done so but working hard to get there. Medi-Cal passed the prescription drug program.

Expanded Medi-Cal Managed Care in thirteen counties is now available. It is mandatory for parents and children, but optional for seniors. They are currently working with Mercer on new rate methodology, which is hoped to be completed by July.

Family PACT will remain on a month-to-month extension with serious negotiations on the waiver. It is still a major question if continuation of services will be provided. They are not yet sure of the outcome. The idea is to keep the program as it is with California paying for all if necessary. This proposal has not been accepted by the federal government.

Does that include state only coverage for Family PACT for HPV? HPV coverage is not in the Family PACT program automatically, but is included in optional benefits for Medi-Cal. The Office of Family Planning has not decided yet how to handle the vaccines.

Federally qualified foster children are exempt from the effects of DRA. Children's Medical Services will be implementing DRA requirements from the beginning. Qualified children will need social security numbers to claim citizenship, which becomes a program access issue for young women attempting to obtain family planning services whom do not have their number on them.

Workgroup Updates

Health care reform: Need to put concerns on the table. A letter stating these concerns and what the unintended consequences to women may be should be written. This letter should include a list of programs that impact women as well as any other issues that may play a role in the lives of women.

The public hearings held by the Commission on the Status of Women resulted in a policy direction. The health issues define many gaps that women recognized. Some of the things that women have identified as gaps will still be there, so they should be kept in mind when framing concerns.

Ruth will talk to the Project Office to see if funding may be available for a contracted consultant to write an analysis of the health care reform issues from a gender specific perspective.

- Proposals to improve a new women's health agenda
- Listing of women's programs with unintended consequence to women
- Principles and what we think are important elements of a women's health agenda

HPV working group: Dissolved

Closing Comments

Beatriz Solís, Chair, Women's Health Council
Marj Plumb, Vice Chair, Women's Health Council

- June 6, 2007: Next Council meeting in Sacramento
- Meeting adjourned at 3:30 p.m.